

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)
COMPLETION INSTRUCTIONS**

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of prior authorization (PA) or Medicaid payment for the services.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to service-specific provider bulletins for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) to the Prior Authorization Request Form (PA/RF), physician prescription, and HealthCheck screen documentation dated within 365 days prior to the grant date being requested and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

GENERAL INSTRUCTIONS

The information contained on this PA/ITA will be used to make a decision about the amount of intensive in-home treatment which will be approved for Medicaid reimbursement. Complete each section as thoroughly as possible. Where noted in these instructions, the provider may attach material which he or she may have in his or her records.

In-home services are generally deemed appropriate for children who meet the criteria of being severely emotionally disturbed (SED) (see Element 16). The provider must also justify the appropriateness of providing the services in the home rather than in the clinic setting. The unique needs of an SED child and his or her family necessitate a team approach. For purposes of Medicaid reimbursement, this team must be led by a Medicaid-certified psychotherapy provider.

All requests for in-home psychotherapy must include documentation of a HealthCheck screen performed by a valid HealthCheck screener and a physician order for in-home psychotherapy, both dated within 365 days prior to the grant date being requested. Prior authorization will not be granted without this documentation. The initial PA may be backdated up to 10 working days prior to the first receipt of the request at Wisconsin Medicaid, but no earlier than the date of the HealthCheck and the physician order. HealthChecks and physician orders expire after one year, so they must be renewed at least annually.

Initial Prior Authorization Request

Complete the PA/RF and the entire PA/ITA. The initial authorization will be for a period of no longer than 13 weeks.

First Reauthorization

- Complete the PA/RF and Sections I-III of the PA/ITA.
- Attach a copy of the HealthCheck verification and physician order dated within 365 days prior to the grant date being requested that were included with the initial authorization. (As long as the HealthCheck verification and physician order submitted in the initial request are timely, they may be used for subsequent requests.)
- Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is

appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan.

- Authorization may be granted for up to 13 weeks.

Subsequent Reauthorizations

- Complete the PA/RF and Sections I-III of the PA/ITA.
- Attach a copy of the HealthCheck verification and the physician order dated within 365 days prior to the grant date being requested that were included with the initial authorization. (As long as the HealthCheck verification and the physician order submitted in the initial request are timely, they may be used for subsequent requests.)
- Attach a brief summary of the treatment to date, including progress on treatment goals, and affirm that the family is appropriately involved in the treatment process. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. If changes were made to the treatment plan, send a copy of the amended or updated plan.
- Summarize the treatment since the previous authorization. The treatment summary information should correspond specifically to the short-term and long-term goals of the previous treatment plan and reference the same measures of improvement. The need for continued in-home treatment must be clearly documented. Where no change is noted in the treatment summary, justify the continued use of the in-home treatment or note how changes in the treatment plan address the lack of progress.
- Specifically address aftercare planning. Discuss plans for terminating in-home treatment and the services which the recipient/family will require.
- Authorization will be for a period of no longer than 13 weeks.

Please check the appropriate box at the top of the PA/ITA to indicate whether this request is an initial, first reauthorization, or subsequent request. Make sure that the appropriate materials are included for the type of request indicated.

Additional Considerations for In-Home Treatment for Substance Abuse

When substance abuse treatment issues are identified as part of the in-home treatment plan, an appropriately qualified alcohol and other drug abuse (AODA) counselor must be identified as part of the treatment team. In-home treatment by a team headed by an AODA counselor (without a certified psychotherapist participating) will generally not be approved. In these instances the provider must document the absence of significant psychopathology and the primary goal of intervention must be motivational with a goal of getting the recipient and/or family involved in traditional outpatient services.

Multiple Services

When a recipient will require PA for other services concurrent to the in-home treatment (e.g., mental health or substance abuse day treatment), a separate PA/RF must be submitted for those services and the appropriate PA attachment and all required materials must be submitted for that other service. Indicate on this PA request that services will be coordinated with the other service provider (if the service will be provided by a different agency). These other services must be identified on the multi-agency treatment plan.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial, exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient

Enter the age of the recipient in numerical form (e.g., 16, 21).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Medicaid-Certified Clinic

Enter the name of the Medicaid-certified psychotherapy clinic which will be billing for the services.

Element 5 — Certified Clinic's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the clinic which will be billing for in-home treatment.

Element 6 — Name — Medicaid-Certified Performing Psychotherapist

Enter the name of the Medicaid-certified psychotherapist who will be the lead member of the team providing services. Master's level psychotherapists must obtain a Medicaid performing provider number in order to bill for these services even if this is not ordinarily required for the type of facility by which they are employed.

Element 7 — Performing Psychotherapist's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the certified psychotherapist identified in Element 6.

Element 8 — Telephone Number — Psychotherapist

Enter the telephone number, including area code, of the certified psychotherapist identified in Element 6.

Element 9 — Discipline — Psychotherapist

Enter the discipline of the certified psychotherapist identified in Element 6 (e.g., MSW, Ph.D.).

SECTION III

Element 10

Enter the requested start date and end date for this authorization request. The initial authorization may be backdated up to 10 working days prior to the receipt of the request at Wisconsin Medicaid if the provider documents the clinical need for beginning services immediately. Note guidelines for length of authorizations under the "General Instructions" section.

Element 11

Enter the total expected number of hours the family will receive direct treatment services over this PA grant period (e.g., the current 13-week period). When two therapists are present at the same time, this is still counted as one hour of treatment received by the family. Also indicate the anticipated pattern of treatment for each team member (e.g., two-hour session once a week for 13 weeks by the certified psychotherapist, two-hour session once a week by the second team member with certified therapist plus one-hour session twice a week for 13 weeks for the second team member independently. More than 104 hours of direct treatment to the family during a 13-week period will not be authorized.

Element 12

Indicate the number of hours the certified psychotherapist will provide direct treatment services to the family and the number of hours that the second team member will provide direct treatment to the family. If more than two providers will be involved in providing services, document that all individuals meet the criteria in these guidelines. Total hours of treatment must not exceed the limitation noted in Element 11. Reimbursement is not allowed for more than two providers for the same treatment session. Since two providers may be providing services at the same time on occasion, the total hours in this section may exceed the number of hours of treatment the family will receive as noted in Element 11. If the primary psychotherapist is involved in treatment more than 50% of the time (e.g., if the primary therapist's direct treatment hours exceed those of the second team member's), special justification should be noted on the request.

Indicate the name and qualifications of the second team member. Attach a résumé, if available. The minimal qualifications must be:

- An individual who possesses at least a bachelor's degree in a behavioral science, a registered nurse (RN), an occupational therapist, a Medicaid-certified AODA counselor, or a professional with equivalent training. The second team member must have at least 1,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- Other individuals who have had at least 2,000 hours of supervised clinical experience working in a program whose primary clientele are emotionally disturbed youth.
- The second team member will be reimbursed at a lower rate, even if that person is a certified Medicaid psychotherapist. The second team member works under the supervision of the certified psychotherapy provider.

If the second team member is a Medicaid-certified psychotherapy provider, only his or her Medicaid provider number need be entered to document his or her qualifications.

Element 13

Indicate the travel time required to provide the service. Travel time should consist of the time to travel from the provider's office to the recipient's home or from the previous appointment to the recipient's home. Travel time exceeding one hour one-way will generally not be authorized.

SECTION IV

Element 14

Present a summary of the mental health assessment and differential diagnosis. Diagnoses on all five axes of the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required. The assessment should address the level of reality testing, thought processes, drive control, relational capacity, and defense functioning. The assessment summary should provide documentation supporting the diagnosis. A psychiatrist or psychologist* must review and sign the summary and diagnosis indicating his or her agreement with the results. In those cases, where the only, or primary, diagnosis is a conduct disorder, the request must provide sufficient justification for the appropriateness of in-home treatment. In those cases where the only, or primary, diagnosis is a psychoactive substance abuse disorder, requests will generally not be approved unless there is sufficient justification for the appropriateness of an in-home intervention (see "Additional Considerations for In-Home Treatment of Substance Abuse" in the General Instructions). Providers may attach copies of an existing assessment if it is no longer than two pages.

Element 15

Present a summary of the recipient's illness/treatment/medication history. In those cases where the recipient has spent significant amounts of time out of the home, or is out of the home at the time of the request, the treatment plan must specifically address the transition, reintegration, and attachment issues. For individuals with significant substance abuse problems, the multi-agency treatment plan must address how these will be addressed. For individuals 16 years and over who have spent significant amounts of time out of the home, the request must discuss why intensive in-home treatment is preferred over preparing the recipient for independent living. *Providers may attach copies of illness/treatment/medication histories that are contained in their records if they do not exceed two pages.*

Element 16

Complete the checklist for determining that an individual meets the criteria for severe emotional disturbance. The following information defines the allowable conditions for b. and c. of the checklist.

For b., the individual must have one of the following diagnoses from the most recent version of the DSM.

Disorders usually first diagnosed in infancy, childhood, and adolescence include:

- Pervasive developmental disorders (coded on Axis II: 299.00; 299.10; 299.80).
- Attention-deficit and disruptive behavior disorders (312.81; 312.82; 312.89; 312.9; 313.81; 314.00; 314.01; 314.9).
- Feeding and eating disorders of infancy or early childhood (307.52; 307.53; 307.59).
- Tic disorders (307.20; 307.22; 307.23).
- Other disorders of infancy, childhood, or adolescence (307.3; 309.21; 313.23; 313.89).

Adult diagnostic categories appropriate for children and adolescents are:

- Substance-related disorders (303.90; 304.00-304.90; 305.00; 305.20-305.70; 305.90, except caffeine intoxication).
- Schizophrenia and other psychotic disorders (293.81; 293.82; 295.10-295.40; 295.60-295.70; 295.90; 297.1; 297.3; 298.9).
- Mood disorders (293.83; 296.00-296.90; 300.4; 301.13; 311).
- Anxiety disorders (300.00-300.02; 300.21-300.23; 300.29; 300.3; 308.3; 309.81).
- Somatoform disorders (300.11; 300.81).
- Dissociative disorders (300.12-300.15; 300.6).
- Sexual and gender identity disorders (302.2-302.4; 302.6; 302.89; 302.9).
- Eating disorders (307.1; 307.51).
- Impulse-control disorders (312.30; 312.33; 312.34).
- Adjustment disorders (309.0; 309.24; 309.28; 309.3; 309.4; 309.9).
- Personality disorders coded on Axis II (301.0; 301.20-301.9).

For c., the symptoms and functional impairments are defined as follows.

*In all instances, psychologist means one who meets the criteria for Medicaid certification at the Ph.D. psychologist level: Licensed in Wisconsin and listed or eligible to be listed in the national register of health care providers in psychology.

Symptoms

1. Psychoactive symptoms — Serious mental illness (e.g., schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
2. Suicidality — The individual must have made one attempt within the last three months or have had significant ideation about or have considered a plan for suicide within the past month.
3. Violence — The individual must be at risk for causing injury to persons or significant damage to property as a result of emotional disturbance.

Functional Impairments (compared to expected developmental level):

1. Functioning in self care — Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
2. Functioning in community — Impairment in community function is manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment, and value system which results in potential involvement or involvement in the juvenile justice system.
3. Functioning in social relationships — Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
4. Functioning in the family — Impairment in family function is manifested by pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others, e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations, and expectations which may result in removal from the family or its equivalent.
5. Functioning at school/work — Impairment in any *one* of the following:
 - a) Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame, such as consistently failing grades, repeated truancy, expulsion, property damage, or violence towards others.
 - b) Meeting the definition of "child with exceptional educational needs" under ch. PI 11, Wis. Admin. Code, and s. 115.76(3), Wis. Stats.
 - c) Impairment at work is the inability to be consistently employed at a self-sustaining level, such as the inability to conform to work schedule, poor relationships with supervisor and other workers, or hostile behavior on the job.

Eligibility criteria may be waived under the following circumstances:

- This individual would otherwise meet the definition of SED, but has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so where the intensity of treatment requested was not provided. Attach explanation.
- This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, and in the judgment of the medical consultant, the nature of the acute episode is such an impairment in functioning that it is likely to be evident without the intensity of the treatment requested. Attach explanation.

Element 17

Present an assessment of the family's strengths and weaknesses. Present evidence that the family is willing to be involved in treatment and is capable of benefiting from treatment. Where the presence of significant psychological dysfunctioning or substance abuse problems is indicated among family members, indicate on the multi-agency treatment plan how these problems will be addressed.

Reimbursement for treatment services primarily directed at recipients over the age of 20 are not available through HealthCheck "Other Services," except as noted in Element 11. Indicate which family members will be involved in treatment. If an assessment of the family's willingness and ability to be involved in treatment is an initial treatment goal, indicate this with at least minimal justification for believing this to be the case. If a family assessment is contained in the psychiatric evaluation or illness/treatment history, indicate this.

Element 18

The provider must specifically identify the rationale for providing services in the home for this child/family. A significant history of failed outpatient treatment along with documentation which identifies a significant risk of out-of-home placement will support such a request. Strong justification is needed if outpatient clinic services have not been previously attempted. The provider should identify specific barriers to the family receiving treatment in a clinic setting or specific advantages for this family receiving services in the home (not simply general advantages of in-home treatment). The provider should present this justification in their own words and not assume that the consultant can infer this from other information submitted with this request.

Element 19

Indicate the expected duration of in-home treatment. Describe services expected to be needed following completion of in-home treatment and transition plans. While providers are expected to indicate their expectations on the initial requests, it is critical that plans for terminating in-home treatment be discussed in any authorizations for services at and beyond six months of treatment.

SECTION V

Element 20

The following materials must be attached and labeled.

- a. The (PA/RF) may be obtained from Wisconsin Medicaid. Use processing type 129 in Element 1. The words "HealthCheck Other Services" should be written *in red* across the top of the form. Providers should use the appropriate procedure codes, modifiers, and descriptions in Elements 14 and 18.

The quantity requested in Element 19 should represent total hours for the grant period requested and Element 20 should represent charges for all hours indicated in Element 19.

- b. The request must include documentation that the recipient had a comprehensive HealthCheck screening within 365 days prior to the grant date being requested. This documentation must be one of the following:
 - A copy of the HealthCheck verification card showing a comprehensive screen in the past year.
 - A copy of the HealthCheck provider's billing form showing a claim for a comprehensive HealthCheck screening.
 - A copy of the HealthCheck provider's Remittance and Status Report showing a claim for a comprehensive HealthCheck screening.
 - A HealthCheck referral from the HealthCheck provider.
 - A letter on the HealthCheck provider's letterhead indicating the date on which they performed a comprehensive HealthCheck screening on the recipient.
 - A physician's prescription for the service with a note on the prescription that this is subsequent to a comprehensive HealthCheck screening performed at his or her practice and the date of the screen.
- c. The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist. The plan must address the role of each system in the overall treatment and the major goals for each agency involved. The plan should be signed by all participants, but to facilitate submission, the provider may document who was involved. Where some agency was not involved in the planning, the provider must document the reason and what attempts were made to include them. The plan should indicate why services in the home are necessary and desirable. *The individual who is coordinating the multi-agency planning should be clearly identified.* A psychiatrist or psychologist must sign either the multi-agency plan or in-home treatment plan. A physician should sign the multi-agency plan if the recipient is taking medication. A model plan may be obtained from the forms page of the Wisconsin Medicaid Web site. To access the model plan, follow these instructions:
 1. Go to www.dhfs.state.wi.us/medicaid/.
 2. Choose "Providers" from the options listed in the Wisconsin Medicaid main menu.
 3. Select "Provider Forms" under the "Provider Publications and Forms" topic area.

If a plan other than the model is used, all information on the model must be included.

- d. The in-home treatment team must complete a treatment plan covering their services. A psychiatrist or psychologist must sign either the in-home treatment plan or the multi-agency treatment plan. Providers may obtain a copy of a model plan from the SED Coordinator or use one of their own which provides equivalent information. The plan must contain measurable goals, specific methods, and an expected time frame for achievement of the goals. The methods must allow for a clear determination that the services provided meet criteria for Medicaid-covered services. Services which are primarily social or recreational in nature are not reimbursable. The plan should clearly identify which team members are providing the Medicaid-covered services being requested.

Services provided to the recipient's parents, foster parents, siblings, or other individuals significantly involved with the recipient are deemed appropriate as part of the in-home treatment plan when these services are required to directly affect the recipient's functioning at home or in the community. Such services include family therapy necessary to deal with issues of family dysfunctioning, behavior training with responsible adults to identify problem behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with the family members which are necessary to ensure their ability to continue their participation

in the in-home treatment process. Interventions with family members or significant others which are primarily for the benefit of these others are not reimbursable under these guidelines, except where these other individuals meet the criteria for intensive in-home treatment (e.g., they are 20 years of age or under) and authorization has been received for these other services under these guidelines. For instance, intervention directed solely at a parent's alcohol abuse is considered substance abuse treatment, is covered by the policy for substance abuse treatment service, and is not reimbursable in the home. However, when the intervention is with the whole family and is focusing on the way in which the parent's alcohol abuse is affecting the child and/or contributing to the problem behaviors, this may be authorized under these guidelines.

Initial treatment goals may include assessment of the recipient and family in the home and these goals may be procedural (e.g., complete assessment, have all members of family attend 75% of meetings, complete substance abuse assessment). Where an assessment is part of the initial intervention, be concrete as to the components of the assessment (e.g., psychiatrist will complete psychiatric evaluation, AODA counselor will complete substance abuse assessment). Where appropriate, identify any standardized assessment tools that will be utilized.

- e. Providers must complete and attach the results of either the Achenbach Child Behavior Checklist or the Child and Adolescent Functional Assessment Scale (CAFAS). Information about these screening instruments is available on the Internet under "Achenbach Behavior Checklist" and "Child and Adolescent Functional Assessment Scale."
- f. A substance abuse assessment must be included if substance abuse-related programming is part of the recipient's treatment program. The assessment may be summarized in Element 14 as part of the psychiatric assessment or illness history.
- g. Attach a physician's prescription for in-home treatment services.

The PA/ITA must be signed and dated by the certified psychotherapy provider who is leading the in-home treatment team. It must also be signed and dated by the supervising therapist if the certified psychotherapy provider is not a Ph.D. psychologist or psychiatrist. In signing, these individuals accept responsibility for supervising the other individuals who are part of the in-home treatment team. In signing, they provide assurance that an individual who meets the criteria for a Medicaid-certified psychotherapy provider will be available to the other team members when they are in the home alone with the child/family.

Element 21 — Signature — Certified Therapist

Enter the signature of the certified therapist.

Element 22 — Date Signed

Enter the month, day, and year the PA/ITA was signed (in MM/DD/YYYY format).

Element 23 — Signature — Supervising Therapist

Enter the signature of the supervising therapist.

Element 24 — Date Signed

Enter the month, day, and year the PA/ITA was signed (in MM/DD/YYYY format).